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NEW ETHICAL RELATIONSHIPS UNDER HEALTH CARE'S NEW STRUCTURE: THE NEED FOR A NEW PARADIGM

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I. INTRODUCTION

MANAGED care is changing the entire business structure of health care as it spreads as a financing mechanism. These changes affect all aspects of medicine, not simply the method of reimbursement. Such changes affect everything from business relationships to clinical practices. As a result, all players in the system are seeing new roles and duties in the ways that they provide and receive health care services.

With new roles and relationships come new ethical responsibilities. Physicians no longer fulfill the same set of duties for patients when managed care companies actively involve themselves in care decisions. They must balance outside pressures against their own clinical judgment. Patients are no longer passive recipients of care relying on the professional judgment of others. They must choose from a variety of managed care plans and health care systems offering different levels of coverage. Insurers are no longer impartial participants in the delivery of health care services, providing reimbursement with minimal regard to their utility. What is more, new organizations that integrate the provision of different levels of health care services are being created, and they fulfill roles in health care delivery that formerly did not exist. As a result, traditional notions of ethical duties no longer automatically apply, and many legal rules that implement those duties are quickly becoming obsolete.

This Article describes the reasons for the spread of managed care and its consequences in the restructuring of clinical and business relationships.¹ It then examines the ethical and legal conflicts that these new relationships pose for major players in the system.² Finally, it proposes a basis for evaluating those conflicts in the restructured health care system.³

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1. For a further discussion of the spread of managed care, see *infra* notes 4-31 and accompanying text.

2. For a further discussion of the legal and ethical conflicts that may arise, see *infra* notes 32-65 and accompanying text.

3. For a further discussion of the evaluation proposal, see *infra* notes 66-81 and accompanying text.

II. RECENT EVOLUTION OF THE HEALTH CARE INDUSTRY

A. *The Spread of Managed Care to Control Costs*

In traditional medical practice, the provider, usually the physician, made largely unsupervised decisions as to the use of health care services on behalf of individual patients. Physicians were bound by ethical dictates to direct patients to obtain services or to render those services themselves based only on their professional judgment of the patient's medical needs.⁴ Rarely did an outside party second guess their decisions. Insurers reimbursed for medical services based largely on trust in the physician's judgment that the services were needed. In most cases, the insurer's decision was not determined by whether the treatment was appropriate for the particular patient, but whether the treatment had been shown overall to serve a valid medical purpose. This system became known as fee-for-service medicine, because reimbursement was based on a fee for each service rendered.⁵

Use of the fee-for-service reimbursement system coincided with a dramatic explosion in the size of the health care industry.⁶ From the 1940s through the 1960s, the number of physicians and hospital beds in the United States grew several fold.⁷ The amount of money spent on health

4. The preamble to the American Medical Association's (AMA's) *Principles of Medical Ethics* provides that "a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." See AMERICAN MED. ASS'N, *Principles of Medical Ethics* (1980), reprinted in BIOETHICS 22, 41 (Rem B. Edwards & Glenn C. Graber eds., 1988).

5. See Christine Gasparovich, Note, *Preferred Provider Organizations and Provider Contracting: New Analysis Under the Sherman Act*, 37 HASTINGS L.J. 377, 377 n.3 (1985). In a fee-for-service system, the patient pays a fee to the doctor when the medical service is rendered. See *id.* The patient is able to choose any health care provider he or she chooses. See *id.* Moreover, an independent physician "determines what service . . . is necessary, provides that service, and sets an independently determined price." *Id.* Under such a system, a physician is given a great deal of autonomy, with ultimate control over his or her output and the price that is charged. See *id.*

Some commentators believe that the fee-for-service system has directly contributed to the escalating cost of health care. See Jonathan Harding, *The Physician's Role in Managed Care: Quality Management, Quality Assurance, and Quality Improvement*, in CRITICAL CONCEPTS IN MEDICAL PRACTICE MANAGEMENT 133, 134 (Robert Tallon ed., 1996) (discussing fee-for-service medicine and rise in cost of medical care).

6. See Harding, *supra* note 5, at 134 (discussing growth of health care industry during height of fee-for-service medicine). Harding argues that "[u]nmanaged fee-for-service care in this country led to over-building of hospitals and high technology equipment with a concomitant expanding spiral of utilization and costs." *Id.* For a further discussion on the growth of the health care industry and statistics on the growth in health care costs, see BARRY R. FURROW ET AL., HEALTH LAW 853 (1995) (noting rise in health care expenditures from \$2590 per family in 1980 to \$7739 per family in 1993).

7. See Eli Ginzberg, *How Many Physicians Are Enough*, 468 ANNALS 205, 209 (1983) (noting nearly 30% increase in number of physicians in decades after World War II); see also AMERICAN HOSP. ASS'N, 1984 HOSPITAL STATISTICS at xvii-xxiii (1984), reprinted in ALAN L. SORKIN, HEALTH CARE AND THE CHANGING ECONOMIC

care services followed suit, with consequent rises in premiums for health insurance.⁸ By the 1970s and into the 1980s, the annual rise in health insurance premiums was outstripping the general rate of inflation by a factor of approximately two each year.⁹

Observers note that fee-for-service reimbursement, with payment based almost solely on the physician's judgment of medical necessity, contains no disincentive for treatments that are not needed or are of marginal benefit.¹⁰ Under fee-for-service reimbursement, physicians and patients are buffered from the financial consequences of ordering and receiving treatments and, therefore, have no direct incentive to be fiscally prudent.¹¹ For example, one study indicates the propensity of physicians to "game" fee-for-service reimbursement systems by increasing the volume of

ENVIRONMENT 70 (1986) (stating that by 1970 there were 848,000 nonfederal short-term hospital beds in United States, up from 505,000 in 1950). Between 1950 and 1970, the average expense per patient per day in a hospital had risen from \$15.62 to \$81.58 and expenses per stay increased from \$127.26 to \$668.96. *See id.*

8. *See* Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 535-36 (1990) (discussing increased health care costs and insurance premiums). In 1965, approximately 5.9% of the United States' gross domestic product (GDP), or \$42 billion, was spent on health care. *See id.* By 1990, that number had grown to nearly 12% or about \$590 billion of the GDP. *See id.* This expenditure is extraordinary when compared to the amount of money spent by other countries. *See* FURROW ET AL., *supra* note 6, at 853 ("In 1991 the United States spent \$2868 per capita, 13.2% of its gross domestic product for health care, compared to \$1659 per capita or 8.5% of GDP in Germany; \$1307 or 6.8% of GDP in Japan; or \$1403 or 6.6% of GDP in the United Kingdom."). This increase has been accompanied by an increase in insurance premiums that during a similar period had increased at a rate of 15% to 20% per year. *See* Weiner, *supra*, at 536; *see also* Laura J. Schacht, Note, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act*, 45 WASH. U. J. URB. & CONTEMP. L. 303, 310 (1994) (noting that to offset increases in health care costs, insurance premiums increased at annual average rate of 21%).

9. *See* FURROW ET AL., *supra* note 6, at 893 (noting that health care costs have grown at twice the level of inflation); *see also* Schacht, *supra* note 8, at 309-10 ("Health care costs have increased annually by more than ten percent, while inflation [has risen] less than five percent.").

10. *See* Leslie C. Giordani, Comment, *A Cost Containment Malpractice Defense: Implications for the Standard of Care and for Indigent Patients*, 26 Hous. L. REV. 1007, 1009 (1989) ("[The fee-for-service] system provides no disincentives to prevent spending for useless or marginally useful procedures."). The effects of managed care and fee-for-service reimbursement on physician incentives is discussed in letters to the editor in the *New England Journal of Medicine*. *See* Letter from Steven Snyder, M.D., 337 NEW ENG. J. MED. 1085 (1997) (criticizing fee-for-service system for its failure to control costs).

11. *See* Harding, *supra* note 5, at 134 (arguing that in fee-for-service system, patients and hospitals do not have economic incentives to demand lower costs). Fee-for-service reimbursement can be linked to the increased cost of health care because it created a system in which "[p]atients were no longer responsible for payment." *Id.* Because patients are isolated from the costs of care by an insurance buffer, "they no longer demanded lower costs." *Id.* *But see* MICHAEL D. REAGAN, CURING THE CRISIS, OPTIONS FOR AMERICA'S HEALTH CARE 77-78 (1992) (arguing that fee-for-service system is not necessarily major cost escalator).

treatments they provide in response to reductions in fee schedule payments.¹² In particular, it is observed that fee-for-service medicine rewards physicians financially for overtreating and can encourage financial relationships among physicians, hospitals and other providers that promote referrals among them for treatments of dubious value.¹³ Abuses related to this conflict motivated the enactment of laws restricting self-referrals.¹⁴

12. See Nguyen Xuan Nguyen and Frederick William Derrick, *Physician Behavioral Response to a Medicare Price Reduction*, 32 HEALTH SERVICES RES. 283, 283-84 (1997) (finding possible connection between fee reductions and increased volume of services). As a result of such a connection, some commentators have cautioned against price controls as a method of dealing with the increased cost of medical care. See *id.* The argument is that any savings induced by price controls could be offset by behavioral responses of health care providers. See *id.* Thus, one commentator noted:

Price controls have been argued to be an effective tool for reducing both the level and the rate of growth of health spending in the United States The savings, however, may be partially countered by the behavioral response. These are volume increases initiated by providers, particularly physicians, who provide more health care goods and services in order to recapture lost revenues. A substantial behavioral response would diminish the potency of price control as an instrument for containing expenditures.

Id.

13. See generally Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL. L. REV. 1003, 1008-15 (1993) (discussing potential for fraud in fee-for-service reimbursement arrangements). According to one commentator, the fee-for-service system is a disaster from the antifraud perspective. See *id.* at 1008-09 (discussing types of fraud inherent in fee-for-service medicine). Bucy stated that [t]o the fraudulent provider, fee-for-service reimbursement encourages the following types of fraud: (1) billing for services not provided; (2) billing for more expensive service than was actually provided; (3) providing and billing for unnecessary services while representing that the services were necessary; and, (4) paying kickbacks for referrals, including self-referrals.

Id. at 1009.

14. See generally 42 U.S.C. §§ 1320a to 1320-7b (1994) (addressing abuses involving federal health care plans). The federal Medicare Act makes it illegal to offer or receive remuneration in return for the referral of patients for services that may be reimbursed by Medicare. See *id.* § 1320a-7b(b). The act provides that

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickbacks, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part [under a Federal or State health care program] . . . or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part [under a Federal or State health care program] . . . shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

In response to the perceived cost pressures of fee-for-service reimbursement, managed care plans spread as an alternative.¹⁵ In managed care organizations, the payment of fees for services rendered is no longer the basis for insurance reimbursement.¹⁶ Promoted by federal legislation in the early 1970s, managed care plans in the form of health maintenance organizations (HMOs) grew on their own in the 1980s and 1990s by offer-

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part [under a Federal or State health care program] . . . or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part [under a Federal or State health care program] . . . shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

Id.; see also 42 U.S.C. § 1395nn(9) (addressing self-referral abuses). Under the Stark amendments, it is illegal to refer a patient for Medicare services to an entity with which the referring physician has a financial relationship. See *id.* The statute provides:

(1) In general —

[I]f a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity designated for health services furnished pursuant to a referral prohibited under subparagraph (A).

Id.

15. See Allison Faber Walsh, Comment, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 210 (1997) (discussing rise of managed care as attempt to curb escalating cost of health care). Managed care is a broad term that is used to cover a wide array of financing arrangements used in the provision of health care. See Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 GA. L. REV. 373, 379 (1997). While the term defies precise definition, managed care can generally be said to “denote health care financing arrangements that attempt to control health care costs by modifying the behavior of providers through clinical rules and financial incentives, that restrict enrolled consumers’ access to providers and care, and that attempt to integrate the delivery and financing of health care.” *Id.*

16. See generally Stephen R. Latham, *Regulations of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 401-05 (1996) (discussing reimbursement methods under managed care plans). Managed care plans reimburse physicians in a number of different ways. See *id.* at 401. There are two broad methods of paying physicians: basic payment arrangements and incentive payment arrangements. See *id.* With a basic payment arrangement, “physicians receive the bulk of their payment for the medical services they supply.” *Id.* at 402. An incentive payment arrangement modifies “the basic payment structure to enhance physicians’ incentives to provide cost-effective care.” *Id.*

ing premiums at substantially lower rates than traditional insurance.¹⁷ The basic approach of HMOs is to lower costs by directly and aggressively reviewing care at several levels before reimbursement and by reversing the financial incentives of physicians that promote overtreatment.¹⁸ All care is channeled through the patient's primary care provider (PCP), a generalist physician who must approve referrals for specialty care and hospitalizations. Many services are also reviewed by the HMO before payment is approved. PCPs are paid based on capitation, a set fee per patient per month that does not vary with increased treatment, so there is no financial gain from overtreating. Physicians may also receive an annual bonus that is inversely related to the number of referrals for specialty and hospital care as an additional disincentive to overrefer.

B. Consequent Changes in Industry Focus

The spread of HMOs has resulted in profound consequences for the structure of the health care industry beyond the change in the method of payment. The new form of reimbursement has created new players in the system and shifted the balance of power among players. Most significantly, the rise of managed care has promoted dramatic consolidation on

17. See 42 U.S.C. § 300e-9 (requiring employers of 25 or more employees to extend option of HMO membership to all employees). The original statute provided in relevant part:

Each employer . . . [that] employed an average of employees of not less than twenty-five, shall . . . include in any health benefits plan offered to its employees . . . the option of membership in qualified health maintenance organizations which are engaged in the provisions of basic and supplemental health services in the areas in which such employees reside.

Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 1310, 87 Stat. 914 (amended 1976).

The growth of managed care became particularly evident in the early 1990s. See generally WALTER A. ZELMAN, *THE CHANGING HEALTH CARE MARKETPLACE* 2-6 (1996) (discussing several developments of 1990s that led to rise of managed care). Furthermore, the gap in premium cost between managed care organizations and fee-for-service plans began to grow. See *id.* At the same time, rates of increase in premiums in managed care organizations declined. See *id.* "The result was a modest stampede toward managed care [B]etween 1988 and 1994, the proportion of the population with employer-sponsored insurance who were in [managed care organizations] rose from 29 percent to 70 percent By the end of 1994 over fifty million people were enrolled in HMOs." *Id.* at 3; see Harding, *supra* note 5, at 133 (stating that number of HMOs skyrocketed from under 23 million in 1985 to roughly 50 million in 1994).

18. See Thomas Palay, *Relational Contracting, Transaction Cost Economics and the Governance of HMOs*, 59 TEMP. L.Q. 927, 942 (1986) (commenting on HMO incentives for physicians to control referrals and hospital utilization and their effect on physician behavior); Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1824 (1995) (contrasting compensation arrangements in new managed care structures when primary care physicians have incentives to deliver less care to patients because they share financial risk with providers with incentives provided by traditional fee-for-service indemnity plans where compensation structure encouraged physicians to deliver more care to patients).

the provider side and new approaches to the delivery of health care services.

1. *Increased Value of Primary Care*

HMOs tightly control patient referrals to specialists and hospitals.¹⁹ Primary care physicians in HMOs can no longer recommend that a patient seek treatment from whomever they think best, because HMOs generally only permit referrals to providers within their systems. Moreover, as discussed, primary care physicians face financial incentives to limit referrals altogether.²⁰ A significant consequence is the need for specialists and hospitals to safeguard their referral sources. They can no longer count on personal and professional relationships with primary care physicians to create a flow of patients. Moreover, primary care physicians may become employed by or otherwise join with organizations controlled by competing specialists and hospitals who demand their referrals. This instability of primary care relationships has created a competitive race among specialists and hospitals to secure a primary care base.

2. *Consolidation*

If the provider side of the industry remains fragmented, managed care companies have considerable bargaining power. They can threaten individual physicians with deselection, exclusion from their plan, if they do not accept mandated rates, or they can steer patients away from physicians and hospitals that insist on maintaining high prices.²¹ In some mar-

19. See Robert Vilensky, *The Liability of Health Maintenance Organizations*, 69 N.Y. ST. B.J. 20, 20 (1997) (stating that, in addition to cost-containment devices, HMOs withhold fixed percentage of doctor's fee "pending economic, quality and utilization profiling"). Such devices provide incentives for doctors to refuse to refer their patients to specialists and hospitals. See *id.*

20. See James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 210 (1996) (finding capitated system of provider reimbursement gives health care providers financial incentives to utilize fewer ancillary services, tests and referrals); Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 470 (1997) (stating that financial incentive plans imposed by HMOs have limited patient referrals); Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743, 1743-44 (1987) (commenting on financial incentives for physicians to limit their use of services and referrals, possibly leading to conflicts with patients' best interests); Barbara H. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1225-26 (1997) (noting that both salary and capitation approaches to physician compensation will result in physicians limiting amount of care delivered and referrals to specialists and hospitals).

21. See Bryan A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 801-02 (1997) (stating that physician dependence on managed care companies, given current health care climate, place physicians at mercy of managed care companies' rates and requirements for fear of deselection and loss of patients and livelihood); Larry J. Pittman, *"Any Willing Provider" Laws and ERISA's Saving*

kets, there are only a handful of managed care plans that control a considerable share of the market. Deselection can cause physicians considerable financial harm. Moreover, in many markets, there are more physicians and hospital beds than the HMOs need to fill their panels, engendering additional competitive pressures on providers. By consolidating, providers gain strength in bargaining with HMOs.

3. *Importance of Efficiency*

HMOs negotiate reimbursement to hospitals and physicians at rates representing the lowest amount that the provider can afford to accept, generally covering only the marginal costs of providing care.²² The rates do not cover, as Medicare and some traditional insurance does, additional expenses such as medical education, research or expansion. Without being able to build a margin for other expenses into their reimbursement, hospitals and physicians must be much more financially cautious. Because revenues are declining under more limited HMO reimbursement, there is pressure to control expenses by becoming more efficient.

III. CONSEQUENCES OF THE NEW INDUSTRY STRUCTURE

A. *Consolidation into Integrated Systems*

The pressures of dealing with managed care have led to the creation of groupings of providers to negotiate jointly with HMOs. These groupings include facilities and individual practitioners providing different levels of care so that a continuum can be offered in a single organization. The most organized and consolidated grouping is an integrated delivery system (IDS), a combination of providers at all levels of care into a single organization.²³ IDSs generally include at least one tertiary hospital, one or more community hospitals, specialist physicians, primary care physicians and providers of ancillary services such as laboratory, radiology and

Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409, 435 (1997) (finding that managed care companies deselect more costly physicians from provider lists); Jennifer L. D'Isidori, Note, *Stop Gagging Physicians!*, HEALTH MATRIX, Winter 1997, at 187, 233 (illustrating effect of HMO deselection on physicians and effects deselection has on physicians' practices).

22. See Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 499 (1997) (explaining that HMOs put hospitals and physicians at risk by paying negotiated per diem rates per case). Danzon reasons that because low level capitation forms of reimbursement allow physicians no additional means to generate revenue to cover the costs of added services or tests they have "incentives to provide too little care." *Id.*; see Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 754 (1997) (noting that HMO requirements that patient-enrollees visit limited panels of approved providers result in HMOs negotiating discounts from providers, networks or physicians bearing financial risk of loss).

23. See John D. Columbo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215, 236 (1994) (noting that rise of first integrated health delivery systems occurred in early 1990s).

physical therapy. They can be structured in many different ways, including control by a physician-led organization or ownership by a hospital.²⁴ They may own their own HMO or receive reimbursement through contracts with HMOs. The most significant common feature is that they offer to providers the essential business advantages of a consolidated structure.²⁵

By combining into an IDS, providers can gain the three necessary elements needed to negotiate with HMOs described above: a secure primary care base, strength in size and a means for promoting efficiency. Every IDS includes a complement of primary care physicians, either directly employed or under contract, who serve as PCPs for HMO members under capitation arrangements and will guarantee the accessibility of the system to patients. By growing larger to gain market share, IDSs can make it more difficult for HMOs to decline to contract with them. By controlling all levels of care, they can reduce duplication of services and can facilitate better coordination among different kinds of providers, making the provision of care more efficient.²⁶

B. *Consequences of IDS Growth and Full-Risk Capitation*

The growth of IDSs and their new relationships with HMOs are beginning to produce significant changes in the structure of health care delivery.²⁷ Many of these changes will enhance patient care and access to health care services. The more substantial changes are creating a system that is more centralized, but also better coordinated than the present one. By affecting the provision of care at a clinical level, however, they raise new ethical and legal concerns. Several of these changes are of particular interest in their conflicting effects.

24. See *id.* at 236-37 (discussing California foundation IDS model). One commentator noted:

In the foundation model, a central entity (the "foundation") controls and manages all the medical facilities in the network, including acute care facilities and clinics. The foundation contracts directly with consumers and insurance companies to provide health care services. The foundation then contracts with doctors and other professionals to provide the promised medical services to the foundation's consumers.

Id.

25. See Danzon, *supra* note 22 at 499 (noting that IDSs offer "potential efficiency gains in the bearing of risk, more cost-effective substitution among services, economies of scale and scope, and monitoring of quality").

26. See Danzon, *supra* note 22, at 499 (noting that net effect of IDS potential efficiency gains "is likely to be a reduction in the need for liability").

27. See Columbo, *supra* note 23, at 236 (noting that HMO and IDS systems bring efficiency and cost reduction to health care delivery); Nia J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures: A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 114-15 (1995) (discussing impact of IDSs and HMOs on structure of health care delivery).

1. *Physicians as Employees*

Many physicians who used to practice as independent businesses now draw regular salaries as employees of larger organizations. They thereby become accountable to corporate entities as well as to themselves and their patients.²⁸ At the same time, the incentive to maximize revenues and to control expenses that owners of a small business directly face are greatly attenuated when a regular salary is guaranteed. Attention to efficiency may suffer as a result.²⁹

2. *Large Primary Care Centers*

By owning large numbers of primary care practices, IDSs can seek economies of scale by combining offices into larger regional centers. These centers compensate for their reduced geographic dispersion by offering longer hours and more modern facilities. Personal attention to patients, however, may be reduced.

3. *Specialization in Primary Care*

Large primary care centers become more efficient when they can triage care to the appropriate level. Within the scope of primary care, patients can be directed based on the complexity and nature of their needs. For example, nurse practitioners can treat routine conditions, and psychologists, social workers, nutrition counselors and occupational therapists can address specialized needs in a primary setting. This broadening of primary care services may come at the cost of a reduction in specialty care.

4. *Coordination of Care Across Levels*

A single IDS can follow patients across different levels of care to ensure, among other elements, that referrals are appropriate, records are transferred and information is exchanged between providers. Under the present system, referral relationships between providers are not systematized, but they depend on individual physician and patient preferences. A result is often a lack of overall coordination in patient care. Supervision of referrals by an IDS, however, can introduce outsiders into clinical relationships whose interests may more directly reflect financial rather than clinical considerations.

28. See Alycia C. Regan, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 638 (1997) (noting that physicians in managed care organizations are accountable to administrators who review treatment recommendations for medical and financial appropriateness).

29. A line of research indicates that productivity declines when physicians switch from private practice to employment settings. See Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 484-88 (1988) (noting individual practice association studies showing that when physicians switch from individual practice to HMOs, financial risk or reward is not enough to encourage efficiency and alter treatment patterns).

5. *Protocol-Driven Health Care*

Many IDSs seek to promote efficiency through standardization of treatments across physicians with protocols directing the process of treating common conditions. Those protocols developed to date focus on expensive chronic conditions for which physicians tend to exhibit wide variations in treatment strategies and consequent variations in quality. Protocols can reduce innovation, however, as well as promoting consistency.

6. *Computerized Information Systems*

Coordination of care, implementation of protocols and utilization profiling require sophisticated information technology. Because the actual management of clinical care is involved, this technology requires complexity well beyond that of traditional medical information systems. The technology to meet these new needs is rapidly evolving, but the maintenance of automated data bases exacerbates confidentiality concerns regarding sensitive patient information.³⁰

7. *Proliferation of Data for Consumers*

The monitoring and direction of medical care results in the production of large amounts of data on provider performance. This data is increasingly becoming available to insurers and employers who purchase health care for insured members and employees. Gradually, much of this data is also becoming available to the general public to guide the selection of physicians and hospitals. The information may be difficult for patients to use, however, because considerable sophistication is required for its interpretation.

8. *Patient-Focused Marketing to Recruit and Retain IDS Members*

The ability of IDSs to command attractive managed care contracts is directly proportional to the number of patients choosing their services. As a result, they often market themselves directly to prospective patients through advertisements and other forms of promotion. They also try to improve patient amenities, such as parking and decor at facilities, to make

30. For further discussion of the confidentiality issues raised in the computerization of medical information, see Robert I. Field, *Overview: Computerized Medical Records Create New Legal and Business Confidentiality Problems*, HEALTHSPAN, Nov. 1994, at 3, 3 (noting that with computerization of medical information, significant threats have surfaced regarding confidentiality). As this author noted:

The nature of computerized information also makes it easier for information to be inadvertently released or to be covertly altered. . . . Without strong security protections, a computer user with the proper access code can retrieve massive amounts of personal medical information from a remote location and print or copy unauthorized patient files. Even with security protections, sophisticated computer hackers present a danger of breach of confidentiality.

Id.

themselves more attractive. Resources devoted to amenities, though, may be diverted from clinical care.

9. *Regression to the Mean in Quality*

On the one hand, the increased attention to primary care will result in improved accessibility to basic care for many who previously found it difficult to obtain. For example, many indigent patients who have relied on hospital emergency rooms for routine primary care now have access to primary physician offices through Medicaid managed care plans. On the other hand, specialty care can be more limited through utilization review and physician disincentives for referrals. The result is that those traditionally underserved see their care improve and those traditionally well served can see their care become more limited. From a public health perspective, the prevalence of managed care does not necessarily reduce or improve health care quality in the aggregate, but rather standardizes quality at an average level for all.³¹

IV. NEW RELATIONSHIPS AND RESPONSIBILITIES IN HEALTH CARE

All of these changes taken together produce new relationships among all players in the health care system. Changes occur, particularly in the relationships between primary and specialty physicians, between hospitals and physicians, between physicians and their patients and among those who pay for care, those who deliver care and those who receive care. Physicians face some of the more obvious conflicts, but payors that are promoting the changes and even patients are in new roles that require ethical scrutiny. A context for analyzing the ethical and legal issues raised by these new relationships is greatly needed.

A. *Physicians*

The most profound new ethical conflicts involve the role of physicians, who are the focal point for the conflicting needs of patients, insurers, IDSs, and themselves. It used to be clear that the ethical obligations of physicians flowed only to their patients, as reflected in the Hippocratic Oath.³² Many physicians today, however, have contracts with insurers or

31. See Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens to Professionalism?*, 1 WIDENER L. SYMP. J. 1, 32-33 (1996) (finding that managed care plans form systems that tie payments to average care and standardize quality at average level for all participants).

32. See STEADMAN'S MEDICAL DICTIONARY 716-17 (25th ed. 1990) (defining Hippocratic Oath). Steadman's quotes the Hippocratic Oath as it appears in a book of the hippocratic collection:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone,

IDSs that put additional parties into the equation. Conflicts are thereby created in ethical duties to all of the other players in the system.

1. *Duties to Employers*

Physicians often have obligations under their employment contracts with IDSs or affiliation agreements with HMOs to control costs, to keep referrals in the system, to limit referrals and to look out for their employer's or network's interests. Failure to honor these obligations could threaten the financial integrity of the system that employs them. Moreover, a physician's own financial interests may be harmed if his employer suffers financially. Does this mean that physicians now have a duty to consider the cost implications of their actions on patients, insurers and employers before recommending a course of treatment?³³

Similar conflicts presently arise regarding occupational medicine physicians who work for companies and regarding psychotherapists in em-

the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

Id.

33. See Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 481 (1987) ("[I]nherent in the HMO structure is the risk that a physician's loyalty will be divided between employer and patient, a risk no less evident in the HMO structure than in the corporate structures held illegal under the corporate practice doctrine decades earlier."); see also David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, HEALTH MATRIX, Winter 1995, at 141, 149 (commenting on triple loyalty between personal financial interests of physicians, needs of patients and the interests of society, resulting from cost consciousness in health care reform); Lisa Rediger Hayward, Comment, *Revising Washington's Corporate Practice of Medicine Doctrine*, 71 WASH. L. REV. 403, 425 (1996) (concluding that HMO structure "creates an inherent risk of physician loyalty to the corporation at the expense of the patient"); Hillman, *supra* note 20, at 1743-44 (focusing on conflict of interests that may arise between patients' best interests and physicians' financial interests when HMOs and IDSs place financial incentives for physicians to limit their use of services and referrals); Sara Mars, Note, *The Corporate Practice of Medicine: A Call for Action*, HEALTH MATRIX, Winter 1997, at 241, 261 (noting that HMO capitation reimbursement may create incentives for physicians to underutilize care at expense of patients' welfare).

ployee assistance plans. In these examples, the physician's primary loyalty is to an outside party, not to the patient. Is this the way all health care is to become?

2. *Duties to HMOs*

Primary care physicians for HMOs are incentivized to limit referrals.³⁴ If a managed care company has a close relationship, such as an exclusive contract with a physician, does the physician have an obligation to look after the company's interests as part of that relationship? Do physicians have any choice in deciding to look out for a company's interests if they risk deselection or severe financial penalties for failing to do so?³⁵

3. *Duties to Patients*

The most profound changes occur in physicians' relationships with their patients. It has been argued that physicians have a new affirmative duty to balance clinical and cost implications in their treatment decisions.³⁶ In particular, three kinds of conflicts with existing legal and ethical rules arise.

34. See Philip Boyle, *Managed Care in Mental Health: A Cure, or a Cure Worse Than the Disease?*, 40 ST. LOUIS U. L.J. 437, 441 (1996) (concluding that HMO financial incentives to control referrals result in incentives to undertreat patients); William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 462 (1991) (noting that HMO payments to physicians based on capitation basis include "financial incentives directed toward minimizing specialist referrals and hospital utilization"); Jim M. Perdue & Stephen R. Baxley, *Cutting Costs—Cutting Care: Can Texas Managed Health Care Systems and HMOs Be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L.J. 23, 26 (1995) (stating that HMOs establish schemes that discourage doctors from referring patients to specialists and hospitals); Jerome M. Staller, *An HMO's Responsibility to Disclose Economic Incentives*, 15 MED. MALPRACTICE L. & STRATEGY 3, 3 (1997) (discussing HMO financial incentives for physicians to limit referrals).

35. See Liang, *supra* note 21, at 801-02 (stating that physician dependence on managed care companies, given current health care climates, place physicians at mercy of managed care companies' rates and requirements for fear of deselection and loss of patients and livelihood).

36. See E. HAavi MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* 2 (1995) (discussing balancing test in which "[p]atients' interests must be weighed against the legitimate competing claims of other patients, of payors, of society as a whole, and sometimes even of the physician himself"). Morreim argues that a new duty of care, requiring physicians to consider resource utilization as well as medical needs in clinical decision making, should evolve for clinical practice under managed care. See *id.* at 69-99 (discussing dilemma faced by physicians, who have obligations to promote patient's best interests, including use of whatever resources are required and their ever decreasing control over those resources).

a. Advocacy for Patients

Recent case law has found a duty of physicians to vigorously appeal coverage denials by insurers on behalf of their patients.³⁷ Physicians,

37. See *Wickline v. State*, 239 Cal. Rptr. 810, 819-20 (Ct. App.) (finding that physician who has primary responsibility in making medical decisions for patient has duty to appeal denial of medical coverage for further treatment), *vacated*, 727 P.2d 753 (Cal. 1986). But see *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 879-80 (Ct. App. 1990) (distinguishing *Wickline* and finding that language in *Wickline*, stating that discharge is sole responsibility of physician, was dicta and did not "correctly state the law relative to causation issues in a tort case").

Wickline was the first case to hold third-party payors potentially liable for the consequences of refusing to authorize further medical treatment. See David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 886 (1991). In *Wickline*, plaintiff was admitted to the hospital for problems with her back and legs. *Wickline*, 239 Cal. Rptr. at 812. She was diagnosed with having an obstructed aorta and a portion of the artery was surgically removed and replaced with a synthetic one. See *id.* The plaintiff was eligible for medical benefits under a California state-administered medicaid program that pre-authorized her admission to the hospital and surgery. See *id.* at 813-14. The plaintiff's recovery went poorly; two more operations on the leg were required. See *id.* at 812. After these surgeries, the plaintiff's physician concluded that she should remain in the hospital for eight more days. See *id.* at 813. The medicaid program in which she was enrolled rejected this request and only authorized a stay of four additional days. See *id.* at 814. Soon after the plaintiff's discharge, her leg became badly infected and ultimately needed to be amputated. See *id.* at 816-17.

The plaintiff brought suit against the State of California, alleging that the medicaid program negligently discontinued her eligibility, causing her to be discharged prematurely while she was still in need of hospital care. See *id.* at 811. The plaintiff further contended that her premature release resulted in the amputation of her leg. See *id.* The *Wickline* court found the treating physician responsible for the plaintiff's injuries, but it did not foreclose the possibility of third-party payor liability. See *id.* at 819 ("Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden."). The court concluded its opinion by emphasizing that cost containment programs must not be allowed to taint a physician's medical judgment. See *id.* at 820 ("While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment.").

In *Wilson*, the decedent was admitted to a hospital while suffering from depression, drug addiction and anorexia. *Wilson*, 271 Cal. Rptr. at 877. The treating physician concluded that the decedent needed to remain in the hospital for at least three weeks to receive the proper care. See *id.* Ten days after decedent arrived at the hospital, his insurance company stated that it would no longer pay for any further hospital care. See *id.* The decedent was discharged from the hospital because he was unable to pay for any further inpatient care. See *id.* at 877-78. Three weeks later, he committed suicide. See *id.* at 878.

The decedent's family brought suit against his insurance company and the doctor who performed the case's utilization review. See *id.* at 880 (claiming breach of insurance contract, negligence and wrongful death). The trial court relied on *Wickline* in reasoning that the decedent's treating physician was responsible for the early discharge from the hospital and granted the defendant insurance company's summary judgment motions. See *id.* The court of appeals, however, distinguished

therefore, seem to have a new legal duty to be patient advocates. Because failure to appeal could jeopardize a patient's care, this may become a new ethical duty consistent with the dictates of the Hippocratic Oath to make their patients' interests paramount.³⁸ There is a logic to imposing this burden, since the physician knows best what care is needed. How does a physician pursue this duty, however, if he or she is an employee of the organization issuing the denial? Can an employee be an effective advocate against his or her own employer? Most legal cases to date have primarily dealt with physicians under contractual relationships with HMOs, not with physicians who are direct employees, which presents more of a direct conflict. The law, therefore, has yet to face the toughest dilemmas.

b. Abandonment of Patients

Common law in most states places physicians under an obligation to continue a course of treatment to the end once a relationship with the patient has been established, whether or not payment is made.³⁹ Under traditional fee-for-service medicine, that relationship begins when the phy-

Wickline on many of the issues and found that much of the language in *Wickline* was "overbroad . . . and constituted dicta." *Id.* at 885. The court rejected the defendant's major argument, premised on *Wickline*, that they were not responsible for the plaintiff's discharge and death because such responsibilities rest with the physician. *See id.* at 879-80 (discussing defendant's *Wickline*-based arguments). The *Wilson* court concluded that "[t]he language in *Wickline* which suggests that civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta." *Id.* at 880. Moreover, the court found that the defendant's decision to discontinue payment for the decedent's hospitalization may have played a significant role in the decedent's death. *See id.* at 883 (stating that there is "sufficient evidence to raise a triable issue of material fact as to whether [defendant's] conduct was a substantial factor in causing decedent's death").

38. *See* LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION* 3 (Henry Sigerist ed., 1943) ("I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.") (quoting Hippocratic Oath)).

39. *See, e.g., Ricks v. Budge*, 64 P.2d 208, 212 (Utah 1937) (finding that once physician begins to treat patient, physician is obligated to continue treating patient to end of course of treatment, regardless of whether payment has been made). In *Ricks*, the plaintiff cut his finger on a piece of barbed wire and his hand subsequently became severely infected. *See id.* at 209-10. The plaintiff sought treatment at the defendant's hospital, where he remained for several days. *See id.* at 210. Having received treatment for his wound and paying for the services that the defendant rendered, the plaintiff left the hospital over the objections of the defendant. *See id.*

The defendant advised the plaintiff to continue the same treatment that had been given to him at the hospital, and that if plaintiff's finger showed any signs of becoming worse, he was to return to the hospital immediately. *See id.* Two days after leaving the hospital, the plaintiff informed the defendant that the condition of his finger had worsened and he needed further treatment. *See id.* Upon arriving at the hospital, the defendant refused to treat the plaintiff until he paid all charges he owed the defendant from a prior, unrelated service. *See id.* The plaintiff left the defendant's hospital and entered another local hospital, where it was found that he was in need of serious surgical and medical attention. *See id.* at 210-11. The

sician agrees to see the patient as a regular patient or to commence an agreed-upon course of treatment.⁴⁰ In contrast to the traditional fee-for-service system, a recent Texas case found that the physician-patient relationship under managed care begins when the patient subscribes to the plan.⁴¹ In this situation, the court said, the patient had bought medical services in advance and the physician was obligated to provide those services under his contract with the HMO.⁴²

The nature of this responsibility raises numerous questions as it evolves under managed care. Does the physician have an obligation to continue to treat a managed care patient when the patient has left the managed care panel or no longer has insurance that applies to the physician's IDS? Who will then pay for the patient's services? Is the physician responsible for insuring that a patient's new IDS includes providers who

plaintiff remained at the other hospital for approximately one month, during which time it became necessary to amputate his injured finger. *See id.* at 211.

The defendant argued that he had no contractual duty to treat the injured plaintiff. *See id.* (arguing further that there was no evidence proving that defendant's refusal to treat plaintiff resulted in any damage to plaintiff's hand). The court rejected the defendants' arguments, stating: "When a physician is employed to attend upon a sick person, his employment continues while the sickness lasts, unless put to an end by the assent of the parties, or revoked by the express dismissal of the physician." *Id.* at 212 (quoting *Lawson v. Conaway*, 16 S.E. 564, 567 (W. Va. 1892)).

40. *See Woolley v. Henderson*, 418 A.2d 1123, 1124 (Me. 1980) (noting that in traditional fee-for-service medical practice physician-patient relationship is usually consensual in nature stemming from implied or express contract). Nevertheless, the *Woolley* court also noted that this relationship may exist where there is "clearly no contractual relationship between the patient and the physician." *Id.* Thus, the *Woolley* court asserted that in traditional fee-for-service medicine, the physician-patient relationship begins as soon as the physician agrees to treat the patient. *See id.*

41. *See Hand v. Tavera*, 864 S.W.2d 678, 679 (Tex. Ct. App. 1993) (ruling that physicians in managed care plans owe duty of care to patients, based on contract to provide services through plan, for wrongfully refusing to approve admission to hospital). In *Hand*, the plaintiff went to the Humana Hospital emergency room complaining of a headache that he had for three days. *See id.* at 678-79. The plaintiff had a history of high blood pressure, and the emergency room physician concluded that the plaintiff's condition warranted that he be admitted to the hospital. *See id.* at 679. The plaintiff presented a Humana Health Care Plan card to the front desk. *See id.* The defendant, who was the doctor in charge of admissions, found that the plaintiff's problems "should be controlled by outpatient medication and follow-up in the office." *Id.* The plaintiff was sent home, and he suffered a stroke several hours later. *See id.*

The defendant asserted that he and the plaintiff had never entered into a physician-patient relationship and, therefore, he did not owe the plaintiff a duty. *See id.* The court rejected this argument and held that "when the health-care plan's insured shows up at a participating hospital emergency room, and the plan's doctor on call is consulted about treatment or admission, there is a physician-patient relationship between the doctor and the insured." *Id.*

42. *See id.* at 680 ("[W]hen a patient who has enrolled in a prepaid medical plan goes to a hospital emergency room and the plan's designated doctor is consulted, the physician-patient relationship exists and the doctor owes the patient a duty of care.").

can competently continue a course of treatment before he or she can relinquish responsibility for treating that patient?

c. Confidentiality

Physicians have obligations under law and ethics to respect the confidentiality of patient medical information.⁴³ Exceptions to this duty are limited, such as situations involving direct threats of harm to third parties, some kinds of public health threats, court orders and patient consent.⁴⁴ Generally, the patient records of employed physicians are owned by the organization that employs them. Under these circumstances, can an employee keep important information from his or her employer? Might he or she even have an affirmative duty to supply an employer with information? For example, should an employed physician keep silent if he or she discovers that a patient consistently seeks unnecessary treatment or otherwise abuses the system thereby burdening the employer's financial resources?

These ethical questions raise particular conflicts for the laws governing the disclosure of medical information that presently receives special confidentiality protection, such as human immunodeficiency virus

43. See, e.g., *Alexander v. Knight*, 177 A.2d 142, 146 (Pa. Super. Ct. 1962) (stating that members of medical profession stand in confidential or fiduciary capacity as to their patients and that this duty involves total care, including safeguarding of personal information). In *Alexander*, the plaintiffs were involved in an automobile accident that required one of them to undergo extensive medical treatment for neck and spine injuries. See *id.* at 143-45. A physician was employed by the defendant's attorneys to interview the injured plaintiff's physicians and to obtain a report from them. See *id.* at 146. The report was obtained for a \$50 fee. See *id.* Contained within the report was the physician's statement that the plaintiff's injuries were "perpetuated by an underlying pre-existing anxiety neurosis and hysteria, centered about an hysterical personality." *Id.* at 145. The plaintiff's physician, however, never sought the plaintiff's consent before he issued the report. See *id.* at 146. The court condemned the actions of the physician employed by the defendant that induced the plaintiff's physician to breach his confidential relationship with his own patient. See *id.* (stating that members of medical profession "owe their patients more than just medical care for which payment is exacted; there is a duty of total care; that includes and comprehends a duty to aid the patient in litigation, to render reports when necessary and to attend court when needed"). The court also emphasized that the physician-patient relationship also encompasses a duty on the part of the physician "to refuse affirmative assistance to the patient's antagonist in litigation." *Id.*

44. See Field, *supra* note 30, at 4 (discussing several exceptions to physician's duty to maintain confidentiality of patient records). For example, most states have statutes mandating that physicians and other health care providers inform public health officials of cases of certain contagious diseases. See *id.* (noting that most states have statutes also requiring physicians and other health care providers to disclose instances of suspected child abuse to public welfare authorities). In addition, a physician may generally disclose a patient's medical records in response to a subpoena and to other health care providers in accordance with the patient's consent. See *id.*

(HIV) status⁴⁵ and drug and alcohol treatment records.⁴⁶ Should all providers in an IDS be entitled to receive such information because the IDS can be seen as one large provider responsible for all care, or should just the treating physician receive it?⁴⁷ An IDS needs access to at least some clinical information if it is to adequately coordinate care. On a practical level, however, how can it make this information widely available internally and maintain confidentiality from outsiders?⁴⁸

45. See Confidentiality of HIV-Related Information Act, 35 PA. CONS. STAT. ANN. §§ 7601-7612 (1993) (seeking to "protect individuals from inappropriate disclosure and subsequent misuse of confidential HIV-related information"). This statute seeks to protect individuals by placing limitations on disclosure: "No person or employee, or agent of such person, who obtains confidential HIV-related information in the course of providing any health or social service or pursuant to a release of confidential HIV-related information under subsection (c) may disclose or be compelled to disclose the information" *Id.* § 7607(a). Only those persons specifically authorized by statute may receive a patient's confidential HIV-related information. See *id.* Among those persons who may review a patient's HIV records are the patient, the physician who ordered the test, an insurer and peer review organizations. See *id.* (stating further that local health departments, persons allowed access under court order and funeral directors responsible for preparing deceased patient for burial may be granted access to patient's HIV-related information).

46. See Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, 42 U.S.C. § 290dd-2 (1994) (discussing confidentiality of patient's records). In pertinent part, this statute provides that:

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall . . . be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under . . . this section.

Id.

47. See generally JOINT COMM'N ON THE ACCREDITATION OF HEALTHCARE ORGS., ACCREDITATION MANUAL FOR HOSPITALS 104 (1992) (requiring that institutions respect rights of patients to "personal privacy and confidentiality of information" within limits of law).

48. See, e.g., Ellen E. Schultz, *Open Secrets: Medical Data Gathered by Firms Can Prove Less Than Confidential*, WALL ST. J., May 18, 1994, at A1 (noting that some employers provide company medical records, including psychotherapy records from employee assistance programs, to their attorneys for use in defending workers compensation claims). This Article notes that employers throughout the country are beginning to access a growing mountain of medical data on their employees, and are becoming more aggressive about using the data, especially when employees file for benefits claiming job-related injuries or stress. See *id.* (noting that much of this medical data is collected through seemingly routine cost-cutting steps such as health promotion programs, fitness surveys and employee assistance programs, which encourage workers to seek counseling). More and more, these records are used in ways employees did not anticipate. See *id.*

B. *Insurers*

Despite their role as agents of change in health care, insurers face new ethical conflicts of their own. In their traditional role under fee-for-service reimbursement, insurers were primarily passive payors for care.⁴⁹ Their only intrusion into clinical decision making was to determine the medical necessity of new treatments in the aggregate, not with regard to their utility for individual patients. Under most health insurance policies, as long as the insured patient's care was medically necessary as determined by the provider, it would be covered and payment would be made.

Almost all care is now managed to at least some extent, and insurers do not rely solely on providers to decide what is medically necessary. Insurers in the form of HMOs now either closely oversee care or provide it themselves through contracted or employed providers.⁵⁰ To whom do insurers owe their loyalty in doing so?

1. *Duties to Employers*

By representing that they hold down costs, HMOs have made promises to, and created expectations in, the payors of their premiums, usually employers.⁵¹ Traditional insurers merely charged whatever premiums the market would bear and did not promise to actively manage costs.⁵² HMOs have taken on an obligation to keep premiums low and have promised to be prudent in spending employers' premium dollars in a

49. See Walsh, *supra* note 15, at 213 (noting that in traditional fee-for-service systems "[p]hysicians exerted exclusive control over the diagnosis and treatment of patients and had complete discretion to choose the method and cost of treatment"). Physicians would submit their bill for services to the insurance company and receive "payment without question." *Id.* In such a system, both physician and patient were insulated, thereby reducing any "incentive for the physician or patient to maintain costs." *Id.*

50. See Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 289 (1995) (noting that HMOs "insure[] for the cost and provide[] for the delivery of health care services by negotiating contractual arrangements with the health care providers to provide comprehensive health care to the defined, voluntarily enrolled patient population"); Michael Kanute, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 841-44 (1989) (defining HMO and discussing several different models of HMOs); Chase-Lubitz, *supra* note 33, at 479 (noting that HMOs provide services to their subscribers by contracting with various health care professionals); see also Weiner, *supra* note 8, at 539-41 (discussing operation of HMOs and contrasting HMOs with traditional fee-for-service rendered health care plans).

51. See *Northwest Med. Lab., Inc. v. Blue Cross & Blue Shield of Or., Inc.*, 794 P.2d 428, 430-31 (Or. 1990) (noting that HMOs are attractive because they claim to reduce costs of premiums to subscribers, reduce cost of services and provide quality comparable to that of traditional indemnity programs).

52. See McGraw, *supra* note 18, at 1822-23 (stating that fee-for-service systems did not try to contain costs of health care, rather "insurance insulated both beneficiaries and providers from the costs of care, [thereby] creat[ing] no incentives to reduce services to contain costs").

way that traditional insurers did not.⁵³ They are thereby taking on some aspects of the role of financial fiduciaries. If they limit care, they will fulfill this obligation. If they do not, they may have breached a promise and perhaps a fiduciary duty to their customer.

2. *Duties to Patients*

If insurers are overseeing care, to what extent are they responsible to the recipients of that care? Can they ethically interfere with the provision of a service with life and death implications without keeping the best interests of the recipients of that service paramount? As a partial answer to that question, a number of cases have imposed liability on HMOs for wrongly denying needed care and for establishing financial incentives that cause practitioners to do so.⁵⁴ Some courts have found managed care plans liable for failing to approve needed treatments upon appeal by member physicians.⁵⁵

These conflicts are exacerbated when the HMO is organized as a for-profit company that is accountable to shareholders, rather than as a non-profit corporation. In the case of for-profit organizations, there is a duty to shareholders to increase the value of the company. The conflict between duties to shareholders and to customers may be difficult when a routine product or service is involved. When a service makes the difference be-

53. See Walsh, *supra* note 15, at 215 (noting that primary goal of HMOs is to lower health care costs and accordingly to implement various cost containment devices to limit treatment to patients and to provide physicians with incentives to perform medical services at lower costs).

54. See, e.g., *Shea v. Esenstein*, 107 F.3d 625, 628 (8th Cir.) (concluding that managed care organizations have fiduciary duty under ERISA to their plan members and that failing to disclose doctor's financial incentive to limit care is breach of that fiduciary duty), *cert. denied*, 118 S. Ct. 297 (1997); *Ardary v. Aetna Health Plans of Cal., Inc.*, 98 F.3d 496, 501 (9th Cir. 1996) (holding that federal Medicare act does not prevent state law claims against HMOs when claimants are seeking damages for alleged improper denial of medical services and misrepresentation to beneficiary of terms of plan); *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 885 (Ct. App. 1990) (holding that insurer's refusal to approve further hospitalization deemed necessary by insured's physician to treat depression, drug addiction and anorexia created triable issue of whether utilization review of medical necessity of hospitalization was substantial factor in causing insured's death); *Pappas v. Asbel*, 675 A.2d 711, 718 (Pa. Super. Ct. 1996) (finding that claim by insured's husband, who was rendered quadriplegic after HMO denied his transfer to nonaffiliated hospital for treatment of spine injuries, was not preempted by ERISA); *Billings v. Union Bankers Ins. Co.*, 918 P.2d 461, 468 (Utah 1996) (holding insurer liable for breach of express coverage and implied covenant of good faith and fair dealing); *McEvay v. GroupHealth*, 570 N.W.2d 397, 407 (Wis. 1997) (finding HMO liable for breach of contract and bad faith in its failure to continue treatment of plaintiff's anorexia nervosa).

55. See *Wickline v. State*, 239 Cal. Rptr. 810, 820 (Ct. App.) (finding third-party payors potentially liable for consequences of refusing to authorize further medical treatment), *vacated*, 727 P.2d 753 (Cal. 1986); see also *Wilson*, 271 Cal. Rptr. at 883 (stating that plaintiff presented sufficient evidence to raise triable issue of material fact as to whether insurer's conduct was substantial factor in causing decedent's death).

tween life and death, the conflict may be unresolvable. As a result, some argue that, in the context of health care, corporate entities such as HMOs cannot be treated merely as traditional profit-centered organizations.⁵⁶ HMOs serve both medical and business functions and should be treated as having a foot in both camps.⁵⁷

3. *Duties to Providers*

Unlike most traditional insurers, HMOs have contracts directly with hospitals and physicians, who may be paid under fee schedules, capitation payments, case rates or other payment arrangements. Patients are generally absolved under HMO contracts and under state law from any direct financial obligations to the providers who treat them.⁵⁸ Such drastic changes raise important issues. Because hospitals and physicians now rely directly on insurers for their livelihood rather than on patient payments, do insurers have a greater obligation to be fair in making payments and in directing patients to use the services of contracted providers? With regard to the provision of care, because HMOs are closely involved in rendering care, do they have an obligation to insure that only competent professionals make treatment decisions? An affirmative answer to the latter question would mean that HMOs have an obligation to oversee IDs with whom they contract to guarantee that appropriate clinicians render services.⁵⁹

56. See Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. MED. & ETHICS 236, 236 (1995) (differentiating between more well-established, nonprofit HMOs and newer for-profit organizations that focus on cost cutting and providing adequate returns on shareholders' investments). Mariner notes that there is "implicit disagreement on whether the [socially accepted standards to judge plans by] should be based on principles of economics, policy, or ethics." *Id.*

Mariner lists the following values by which to judge health care institutions: "humaness, reciprocal benefit, trust, fairness, dignity, gratitude, service and stewardship." *Id.* at 239 (citing Stanley Joel Reiser, *The Ethical Life of Health Care Organizations*, 24 HASTINGS CENTER REP. 28, 28-35 (1994)). These values, however, "may be incompatible with achieving the [managed care organization's] financial goals." *Id.*

A further problem exists in education. For example, most business ethics text books do not include discussions regarding organizations that deliver medical services. *See id.* "Most tend to focus on ethical principles for individual personal conduct rather than the actions or policies of an organization." *Id.*

57. *See id.* at 241-43 ("[E]thical standards for MCOs should recognize the organizations' medical responsibilities as well as their business functions."). In achieving this goal, Mariner emphasizes that the organization's purpose, unlike a doctor's practice focusing on individual patients, is to ensure that all enrollees receive proper care. *See id.* at 242. Mariner urges "acceptable solutions" to the inherent conflict arising between the needs of the population and the individual client. *See id.* One such example is the elimination of "expensive, experimental therapies in order to provide more preventative services." *Id.*

58. *See, e.g.*, 40 PA. CONS. STAT. ANN. §§ 1551-1568 (1993) (requiring that patients not be held liable for covered services under HMO contracts with providers).

59. See Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 225 (1995) (discussing problems doc-

C. *Patients*

Even patients face new ethical obligations giving rise to ethical conflicts under the new structure of health care. Previously, patients would enter into a relationship with a physician who would treat them over a course of time. The patient was essentially a passive recipient of services rendered by an expert of the patient's choice. Now, the physician may change when the patient's health plan does, or a patient may see a different physician each time he or she visits the same primary care center. The relationship is with the HMO or IDS, not with an individual physician. Because patients cannot play the same passive roles as they had in the past, they can now be considered as more active participants in health care decision making.⁶⁰ New ethical obligations may accompany this new posture.

1. *Advocacy for Their Own Care*

Patients can no longer expect services that their physician finds advisable to be covered by insurance reimbursement with minimal question. Although physicians may have a legal obligation to appeal wrongful coverage denials and insurers may have a legal obligation to cover medically necessary services, patients have chosen their insurance plan and their PCP within the plan, whose conscientiousness with regard to those obligations may vary. Patients must be aware of the implications of coverage determinations and of their rights regarding them to be effective consumers who choose physicians and insurers and in order to thereby be effective recipients of care. Patients, therefore, can be seen as sharing in the ethical obligations of physicians and insurers to see that care is adequately provided.

It is not clear, however, how patients will assume such responsibility. When care is denied, do patients have an obligation to appeal and to fight for coverage? Can the burden be put on patients to pursue appeals with payors or IDSs? Patients often lack the knowledge and sophistication to

tors face when "a stranger in another city, who has no clinical experience, calls the doctor and tells her to discharge a patient, or denies approval for a test").

60. Recognizing that the role of patients in the new managed care environment is changing, some states have attempted to curb a perceived deterioration of the physician-patient relationship. See Regan, *supra* note 28, at 642-43 (discussing state regulation aimed at preventing managed care organizations from interfering with certain communications between providers and patients); see also COLO. REV. § 10-16-121(1)(a) (West Supp. 1996) (requiring certain contract provisions in contracts between carriers and providers, including provision that carrier shall be prohibited from "protesting or expressing disagreement" with medical decisions, policies or practices of provider); DEL. CODE ANN. tit. 18, § 3303(8) (1989 & Supp. 1996) ("The [health insurance] policy shall contain no provision or nondisclosure clause preventing physicians or other health care providers from giving patients information regarding diagnoses, prognoses and treatment options."). These state laws assume that if physicians and patients interact as independently as possible, the quality of care will not decrease. Regan, *supra* note 28, at 642-43. Specifically, the "[d]isclosure provisions . . . aim to create [active], informed consumers." *Id.* at 658.

take such active roles and are certainly the most vulnerable players in the system. Therefore, individual patient responsibility must be balanced against the reasonable expectations of their capabilities.

2. *Respecting the Financial Implications of Their Care*

In many cases, patients will inevitably receive care that is not medically necessary, either because of their own or their physician's insistence. Should they be responsible for the financial implications of receiving such care? Policy makers observe that costs are an important element in overall public health and cannot be analyzed independently of quality.⁶¹ Perhaps patients now have a duty to avoid selfishness in demanding medical services that they know to be of marginal value. For example, patients in HMOs have less freedom to request diagnostic services that may provide reassurance, but are not directly related to a demonstrated medical need. Some argue that when a patient joins an HMO, he or she has made a trade-off in which this freedom is reduced in return for lower premiums.⁶² If patients do not respect the financial implications of this trade-off, they have threatened the basis for health care cost control. Such behavior can be seen as selfish in some circumstances and perhaps as ethically suspect.

3. *Becoming Informed Consumers*

HMOs and IDSs will compete based on cost and quality, which will be demonstrated and marketed through statistical measures. The data and analyses will likely be voluminous and difficult for an unsophisticated analyst to understand.⁶³ Should patients be responsible for making informed

61. See Michael J. Malinowski, *Capitation Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 359 (1996) (discussing cost implications in medical ethics). Malinowski stated: "The reality of modern medicine, meaning the medicine of today and tomorrow, is that costs do matter. They matter a great deal. Accordingly, medical ethics must acquire a social conscience . . ." *Id.* Additionally, any discussion of the balancing of cost and quality must include the issue of health care rationing. Rationing techniques include inquiring into and prescribing less expensive drugs, avoiding unnecessary referrals to specialists and denying treatments with marginal benefits. *Id.* at 340. To supplement the effectiveness of rationing, Malinowski urges that "(1) patients understand the limits of their coverage when they purchase it, (2) patients understand that rationing is making their insurance affordable, and (3) health care ethical norms [be] expanded to more comfortably address cases in which high costs are not justified by minor expected results." *Id.*

62. See Christensen, *supra* note 59, at 223 ("Subscribers premiums or dues are set by the marketplace . . . [but the tradeoff is] reducing the amount spent on doctors, tests, treatments and hospitalization.").

63. See Alice G. Gosfield, *The Legal Subtext of the Managed Care Environment: A Practitioner's Perspective*, 23 J.L. MED. & ETHICS 230, 231 (1995) (discussing range of health care data available to consumers). The amount and variety of health care data is "dizzying, ranging from procedure and device effectiveness, to customer satisfaction and disenrollment rates, to the extent of provision of preventative health services with what outcomes to populations." *Id.* The commentator also noted that "[t]he producers [of this data] range from public legislatively spawned bodies . . . to private managed care entities." *Id.*

health care purchasing decisions based on this information? The range of data that is already available for health care consumers is extensive. Existing sources include the National Committee on Quality Assurance (NCQA), the Healthplan Employer Data and Information Set and the Pennsylvania Health Care Cost Containment Council.⁶⁴ Many more will be available in the future. Some believe that patients should be accountable for their health care choices when they make trade-offs between cost and quality in choosing a health plan.⁶⁵ This puts a burden on patients who may not have the sophistication necessary to meet it.

64. See Regan, *supra* note 28, at 674-75 ("[I]n 1990, an independent nonprofit accreditation program known as the National Committee for Quality Assurance (NCQA) was formed to evaluate and compare [managed care organizations]."); see also Aynah V. Askanas, *Physician Terminations in Managed Care: Why Are They Occurring? How Do We Ensure They Are Just?*, 1 HEALTH MATRIX, 67, 175 (stating that NCQA devises report card for each HMO using what is known as "Healthplan Employer Data Information Set"); Robert Hackey, *New Wine in Old Bottles: Certificate of Need Enters the 1990s*, 18 J. HEALTH, POL., POL'Y & L. 927, 931 (1993) (explaining that Pennsylvania's Health Care Cost Containment Council has published "outcomes data for each of the state's acute care hospitals since 1989").

65. See E. Haavi Morreim, *Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice*, 23 J. L., MED. & ETHICS 247, 254-55 (1995) (noting that patients now face accountability for health care purchasing decisions). Moreover, some courts take a strictly contractual approach to denial of coverage decisions and emphasize that patients should bear some responsibilities in choosing health care plans. See *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405, 1407 (7th Cir. 1994) (expressing sympathy for plaintiff denied coverage, but rejecting such sympathy as a basis for judicial recovery); *Loyola Univ. of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 903 (7th Cir. 1993) (same).

In *Humana*, a participant in a group health plan provided by Humana Insurance underwent heart surgery. *Humana*, 996 F.2d at 896. Problems during the surgery left the attending surgeon with the option of letting the patient die or implanting a total artificial heart. See *id.* at 897. The surgeon opted for the implant, but the patient died two weeks later. See *id.* *Humana* refused to pay for the implant because such procedures were considered experimental by the insurance company. See *id.* According to the terms of the insurance plan, any experimental procedures must be pre-approved. See *id.* at 901. In holding for *Humana*, the court determined that because the case was brought in contract, the language of the benefit plan controlled and the insurance company had the right to determine what constituted experimental procedures. See *id.* at 903 (emphasizing that the terms of the insurance plan controlled and that "*Humana's* humanity [was] not an issue").

Similarly in *Fuja*, a participant in a group health plan sued her insurer for failing to pay for what the insurance company deemed experimental treatment. *Fuja*, 18 F.3d at 1407. The insurance company "refused to cover the treatment because it did not fall within the parameters of procedures that are 'medically necessary' as defined in the insurance contract." *Id.* As in *Humana*, the *Fuja* court analyzed the case as a contract case and determined that the contract language was unambiguous. *Id.* at 1412. Because the plaintiff, who was a plan participant, was "informed that her treatment [would] be furnished in connection with medical research," the procedure clearly fell within the prohibitory language of the contract. See *id.* at 1410.

Therefore, Morreim concludes that judicial sentiment cannot always overcome the notion that "patients can and should bear some responsibility for their own conduct, both in choosing health plans and in fulfilling contractual obligations once they select one." Morreim, *supra*, at 255.

V. A SUGGESTED ETHICAL PARADIGM FOR THE RESTRUCTURED HEALTH CARE INDUSTRY

A review of these new sets of ethical conflicts reveals a common theme. All manifest the conflict between cost and quality in health care. Large organizations, such as HMOs and IDSs, particularly when they are structured on a for-profit basis, must control costs to survive and to thrive. These organizations are more prominent in health care recently because there is a need for new forces in the industry that can counter the recent relentless rise in costs. At the same time, quality cannot ethically be compromised as a goal. It can be subjected to a balancing with cost factors, but only up to a point because such fundamental interests rest on the quality of health care received. The new ethical conflicts, therefore, can be seen as tests of the limits of how far we can go in individual instances in controlling costs at the expense of quality.

A. *Maintaining the Value of the Best Interests of the Patient*

One could conclude that all elements of the health care system should be concerned solely with the best interests of the patients. The history of health care cost increases has taught us, however, that larger societal interests in cost control and access cannot be ignored. A balance is needed. Conversely, if the interests of the patient are not always placed first, we risk compromising a fundamental need. We may even create a disincentive for patients to seek care at all for fear that the system is not truly concerned with their welfare. In an industry that deals with life and death, we must be extremely careful in limiting any responsibilities owed to the customer.

B. *A Suggested Paradigm: Rebuttable Presumption of Patient Primacy*

One approach to resolving the ethical and legal conflicts described above would be to use a process of shifting burdens of persuasion. Under this approach, every health care decision would initially be measured according to an overriding principle that it should first consider the best interests of the patient. A decision that does not consider the patient's interests first must then be justified by compelling cost or other considerations that will benefit other goals that maintain the integrity of the health care system. If such an alternative justification cannot be made, then an ethical duty has been breached.

Under this paradigm, everyone's duty, including insurers, providers and patients, involves a primary, but not absolute, obligation to maximize the well-being of every individual patient entering the system. Every time a competing goal comes into play, it must be demonstrated that individual patient care was maximized to the extent possible before the other goal is effectuated. It must also be shown that the competing goal has a desirable impact on health care in some other way. The process of analyzing shift-

ing burdens based on patient interests can apply to both the formulation of overriding ethical principles and to legal rules that effectuate those principles in individual cases.

For example, a doctor referring a patient out of network, contrary to the dictates of a contract with an IDS or HMO could justify the decision to his or her IDS or HMO as being in the best interests of the patient. This would serve as an affirmative defense by the physician to a breach of contract claim and would form a rebuttable presumption that the physician acted appropriately. The employer could rebut this defense by arguing that the interests of the patient in question did not outweigh the threat to the financial integrity of the system. The dispute would be resolved through a factual determination of the impact of the competing health care goals under the facts of the specific case with the burden of persuasion on the party arguing against the individual patient's interests.

Another example would be the physician's duty to treat a patient through a course of treatment regardless of payment—the legal and ethical duty not to abandon the patient. An ethical analysis would first look to the patient's best interests, which in this case would require that the traditional duty apply and the physician be required to treat until a substitute physician willing and qualified to take the patient is identified. What if the patient must switch insurance plans and the new plan does not cover the services of the first physician? The first physician's duty would be to determine that a substitute physician was available in the patient's new insurance plan and to communicate clinical information to him or her, if necessary. Once it became apparent that a suitable substitute is available in the other system, the physician's duty to the patient would cease. The burden would then shift to the new HMO or IDS to provide that continuing care. If the new IDS or HMO did not have a suitable provider, the first physician would be obliged to continue to treat the patient, although with a claim against the new IDS or HMO for reimbursement for the services.

A third example involves the role of patients in advocating for their own care. Could an HMO defend against a claim for wrongly denying care by arguing that the patient did not vigorously pursue an appeal on his or her own behalf? The first question in analyzing this situation would be whether the interest of the patient were harmed through the denial of care that was medically necessary. If he or she had been, then the next question would be whether placing the burden on the patient to appeal the claim denial can be justified by another health care goal, such as the need to make patients active participants in care decisions to promote sensitivity to costs. The HMO would have to demonstrate that such a policy actually did control costs without unreasonably limiting necessary care. The ultimate impact on health care, both of the individual patient and of the larger cohort of patients receiving care under the same plan, would be the guiding factors in analyzing the ethical duties of patients and of the HMO. The burden of persuasion in a legal proceeding to assign liability

for a breach of those duties would be on the party arguing against the interests of the individual patient.

The exact balance of different ethical and legal duties under this paradigm would be determined as cases arise and the new industry structure evolves. Regulators would enforce it in overseeing the industry, and courts would enforce it in imposing liability standards. In essence, considerations of patient care would not automatically resolve every conflict, but would form the starting point for any analysis.

C. *The Inherent Conflict in For-Profit Medicine Under the Suggested Paradigm*

Some aspects of the reorganized health care industry may not be amenable to a paradigm for ethical and legal analyses focused on the interests of patients. In particular, for-profit corporate medicine may present an ethical and legal paradigm of its own that is incompatible with a principle that patient interests must always be considered first. For-profit medicine used to mean individual physicians and other practitioners who made money by providing services. Other elements of the system involving larger corporate structures, such as hospitals and insurance companies, were mostly structured on a nonprofit basis. Additionally, the corporate practice of medicine doctrine limited for-profit corporate entry into health care in most states.⁶⁶

In the name of cost control, we have encouraged the creation of larger corporate health care entities, such as those that own and operate many HMOs. Exceptions to the corporate practice of medicine doctrine have been recognized to make these organizations legally permissible.⁶⁷ This new business structure has fostered many positive results, including

66. See Arnold J. Rosoff, *The Business of Medicine: Problems with the Corporate Practice of Medicine Doctrine*, 17 CUMB. L. REV. 485, 490 (1987) (describing origin, justification and evolution of corporate practice of medicine doctrine). An example of a typical state statute that embodies the doctrine reads in pertinent part: "No corporation shall practice . . . or hold itself out as practicing dentistry. No person shall practice . . . dentistry as an officer, agent or employee of any corporation, or under the name of any corporation. No person shall practice . . . dentistry under any firm name or trade name . . ." N.J. STAT. ANN. § 45:6-12 (West 1996).

The corporate practice of medicine doctrine developed out of state licensure acts, which prohibited and punished the unauthorized practice of medicine. See Rosoff, *supra*, at 491. Generally, the doctrine was intended to prevent organizations from exploiting the health care field for profit. See *id.* More recently, however, "the involvement of corporations at all levels is pervasive, and is increasingly accepted as legitimate and even desirable." *Id.* at 497. Despite this fact, many states remain committed to the doctrine. See *id.*

67. See Mars, *supra* note 33, at 252 (noting that courts and legislatures have permitted exceptions to corporate practice of medicine doctrine for professional corporations, nonprofit hospitals and HMOs); see also George F. Indest, III & Barbara A. Egolf, *Is Medicine Headed for an Assembly Line? Exploring the Doctrine of the Unauthorized Corporate Practice of Medicine*, BUS. L. TODAY, July-Aug. 1997, at 32, 34-35 (noting that "[c]ertain types of corporations may legally hire doctors or share in its doctor-employee's income" such as professional service corporations, faculty-practice plans and HMO or other managed care entities).

more primary care, more coordinated care and more focus on patient amenities. When organized on a for-profit basis, however, this structure can also create conflicts of interest between business and medical ethical responsibilities.⁶⁸ Managers of for-profit businesses have a fiduciary obligation, recognized in ethics and in law, to put the interests of the equity owners whom they serve first.⁶⁹ How can they fulfill this obligation under a paradigm that requires the customer's interests to be the focus of their ethical and legal duties? It may be that the profit-making obligations of for-profit corporate entities are too great to balance against the interests of their customers, even if they are life and death interests. The paradigm of placing patient care as the primary value in any ethical or legal analysis, therefore, may not be consistent with the role and duties of a for-profit corporation.

Nonprofit corporations, however, merely have an obligation to maintain fiscal health.⁷⁰ This is a duty owed to bondholders, customers and the general public. They do not have a duty to maximize short-term profits for shareholders.⁷¹ By devoting resources to patient care above the de-

68. See Mariner, *supra* note 56, at 237 (stating that in for-profit organizations, "[e]thical principles are sometimes conflated with economic and political goals"). Managed care organizations focus on cutting costs and ensuring adequate returns on investment to their shareholders. See *id.* "[Managed care organizations] face difficulties when achievement of their mission to provide medical care conflicts with their obligation to preserve their assets. This is especially true in the case of for-profit [managed care organizations], which may be under pressure to maintain stock prices and to pay dividends." *Id.* at 238.

Patients, however, rely on physicians to advise them and expect independent judgment from the physician in making significant medical decisions for them. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 246-55 (1995) (discussing physicians' duties and potential conflicts of interests). Physicians can abuse this trust by advancing their personal interests or those of other parties. See *id.* Patients, however, are usually in a poor position to monitor physicians, to second-guess their judgment or to discover and sanction breaches of trust. See *id.* at 246. "Physicians have divided loyalties when they perform roles other than patient care In these circumstances, pursuing legitimate roles may cause physicians to act in ways that are not in the best interests of at least some of their patients." *Id.* at 251 (citation omitted). Conflict arises with regard to HMOs and other managed care organizations because services that are only slightly profitable might be denied to patients in order to "promote the institution's interest." *Id.* "Patients would then be one of the many parties that have a claim on physicians' loyalty, but not one that overrides the claims of other parties." *Id.* at 254.

69. See Mars, *supra* note 33, at 256 (noting difference between nonprofit and for-profit organizations as latter's duty and ability to distribute earnings to management, private shareholders or other institutional decision makers).

70. See Lewis D. Solomon & Kimberly J. Benjamin, *Intentional Communities: A Primer*, 23 OHIO N.U. L. REV. 143, 163 (1996) (stating that "managers of nonprofits have a duty to donors and the general public to use funds entrusted to them in an effective and proper manner").

71. See Andrea L. Castro, Comment, *Overview of the Tax Treatment of Nonprofit Hospitals and Their For-Profit Subsidiaries: A Short-Sighted View Could Be Very Bad Medicine*, 15 PACE L. REV. 501, 528 (1995) (noting that nonprofits do not face the same bottom line pressures that for-profit organizations face); Hayward, *supra* note

mands of shareholders and of the market, they are not breaching a fiduciary duty and they are not subject to a conflict of interest.

The operations of nonprofit corporations are subject to substantial criticism, much of it with merit.⁷² It is argued that nonprofit health care corporations can behave with the same competitive fierceness as for-profits.⁷³ In many markets, hospitals and health care systems are extremely aggressive in seeking market share from competitors.⁷⁴ Many for-profit corporations object to the tax advantages that nonprofit organizations enjoy, arguing that their role and behavior are no different.⁷⁵ There is considerable debate, moreover, as to whether nonprofit hospitals provide more indigent care than their for-profit counterparts.⁷⁶

33, at 410 (discussing absence of conflict between professional and profit motives in nonprofit organizations); Mars, *supra* note 33, at 257-58 (noting that earnings in nonprofits cannot be distributed to private shareholders, but instead must be used for tax-exempt activities).

72. See Evelyn Brody, *Agents Without Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms*, 40 N.Y.L. SCH. L. REV. 457, 463-64 (1996).

73. See Brody, *id.* at 490 (arguing that competition exists between nonprofits that will weed out nonperforming or nonresponsive organizations). Nonprofits, in short, struggle to survive and to achieve their goals, just like every other organization. See *id.* at 469.

The notion that nonprofit organizations are just as competitive as for-profit organizations was successfully raised and argued by a county seeking to limit the tax-exempt status of a nonprofit health system that claimed to be a charity. See *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 276 (Utah 1985) (finding that nonprofit defendant generated income substantially higher than its expenses). The court stated that "there is serious question regarding the constitutional propriety of subsidies from Utah County taxpayers being used to give certain entities a substantial competitive edge in what is essentially a commercial marketplace." *Id.*

74. See Brody, *supra* note 72, at 469 (noting that nonprofits compete for directors, donations, government contracts and grants, employees, volunteers and clientele); Deborah A. DeMott, *Self-Dealing Transactions in Nonprofit Corporations*, 59 BROOK. L. REV. 131, 132 (1993) ("As of 1990, revenues generated by nonprofits accounted for roughly fifteen percent of the nation's gross national product.").

75. See Mars, *supra* note 33, at 256 (noting that to get tax-exempt status nonprofits must comply with § 501(c)(3) of Internal Revenue Code). To receive tax-exempt status, nonprofit corporations must be "organized and operated exclusively for religious, charitable, scientific . . . or educational purposes . . ." I.R.C. § 501(c)(3) (1994).

One commentator has noted that "today's not-for-profit hospitals are being heavily scrutinized and criticized for their lack of commitment to charitable purposes." Mars, *supra* note 33, at 256. They are tending to approximate for-profit entities in their structure and their behavior. See *id.* (arguing that if nonprofits imitate for-profit entities, then nonprofit exception to corporate practice doctrine appears to be arbitrary).

76. See INSTITUTE OF MED., FOR-PROFIT ENTERPRISE IN HEALTH CARE 101 (Bradford H. Gray ed., 1986); see also M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 316-17 (1995) (stating that difference in amount of below-cost care provided to poor by nonprofit and for-profit corporations is "bitterly disputed"). One commentator noted:

Nonprofit corporations, however, do not face the same pressures as for-profits to ignore other values in favor of profits. There are no shareholders and investment analysts to answer to in terms of stock price and dividends.⁷⁷ The boards of nonprofit organizations are generally uncompensated and have no equity interest in the organization.⁷⁸ The performance of the board is not measured in terms of share price, but in terms of the success of the organization's community mission.⁷⁹ Board members can meet their ethical and fiduciary obligations by considering patient care as their primary concern in a way that for-profit directors would find more difficult.

Nonprofit corporations are also often criticized as inefficient.⁸⁰ To the extent that they are buffered from profit-making pressures, they can

Studies of comparable nonprofit and for-profit hospitals, matched on the basis of community demographics and patient characteristics, have not shown a significant difference in rates of uncompensated care. Thus the proposition that the nonprofit form itself generates more free and below-cost care than for-profit form is inconsistent with the available data.

Id. at 317-18. Another commentator suggested that part of the reason for the decline of medical services for indigent patients is that nonprofits can no longer compete with for-profit hospitals that have begun to capture the medical market. See A. Kay B. Roska, Comment, *Nonprofit Hospitals: The Relationship Between Charitable Tax Exemptions and Medical Care for Indigents*, 43 Sw. L.J. 759, 780-81 (1989). As a result, nonprofits "changed their focus from caring for the sick and the poor to attracting paying patients." See *id.* (arguing that state legislatures should address this problem by establishing treatment of poor as prerequisite to charitable tax-exempt status).

77. See Mars, *supra* note 33, at 257 (stating general rule that earnings of nonprofit organizations cannot be distributed to private shareholders or management); see also DeMott, *supra* note 74, at 132 (noting primary difference between for-profit and nonprofit organizations is that nonprofit organizations cannot pay dividends or distribute net income to persons who control them). Stated simply, "[m]embers of a nonprofit . . . do not have a proprietary interest in the corporation comparable to the interest that shareholders have in a for-profit corporation." *Id.*

78. See DeMott, *supra* note 74, at 140 ("Most nonprofits do not compensate their directors directly."). But see Mars, *supra* note 33, at 257-58 (noting that although income cannot be distributed to management or shareholders of nonprofit organization, nonprofits might distribute large salaries to hospital administrators or employ excessively large staffs).

79. Compare Mary Frances Budig et al., *Pledges to Nonprofit Organizations: Are They Enforceable and Must They Be Enforced?*, 27 U.S.F. L. REV. 47, 63 (1992) ("Nonprofit corporations operate to achieve the organization's specific public, charitable, or religious purposes."), with Robin Dimieri and Stephen Weiner, *The Public Interest and Governing Boards of Nonprofit Health Care Institutions*, 34 VAND. L. REV. 1029, 1038 (1981) (noting that nonprofit organization's profit margin is measure of organization's efficiency and effectiveness). In nonprofit organizations, however, one cannot use only one factor to measure efficiency and effectiveness because economic efficiency is not always the most effective means of achieving the organization's purpose. See *id.* (noting factors utilized in measurement of performance in nonprofit and for-profit organizations).

80. See Brody, *supra* note 72, at 463-64 (noting that there is no guarantee that nonprofit organizations will spend their money in ways that avoid inefficient expenditures).

be more wasteful of resources and less attentive to customer needs. These inefficiencies may be lessening, however, because of the competitive pressures to maintain efficiency in dealing with HMOs. Inefficient nonprofit corporations cannot survive under managed care because the low reimbursement rates will not permit it.⁸¹ If nonprofit corporations can survive in the new structure of the health care industry, they will have to be more efficient and sensitive to their customers.

VI. CONCLUSION

The restructuring of the health care industry in response to the spread of managed care is having profound effects on basic relationships between players in the system. The result is a set of new ethical obligations that balance the interests of individual patients and the integrity of the overall system and of its components. This balance reflects a level of complexity and contradictions in ethical and business relationships in health care that we have not yet seen. The industry, however, has reached a level of organizational sophistication that we have not previously seen. Within this new complex system, clinical quality may be lost as a value if it is not treated as a starting point for any ethical analysis. Those operating the system should be in an ethical position to accord it this measure of significance.

81. See *id.* at 492 (noting that survival is "measure of a nonprofit organization's effectiveness"). Survival means that "important functions of effective acquisition and maintenance of resources are performed." See *id.* (quoting Richard D. Heimovics & Robert D. Herman, *The Salient Management Skills: A Conceptual Framework for a Curriculum for Managers in Nonprofit Organizations*, 19 AM. REV. PUB. ADMIN. 295, 302 (1989)).